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ABSTRACT

Hawaii's Health and Education Collaboration Project (HEC) is intended to develop a personnel preparation model that promotes working relationships among trained collaborative providers and keeps families pivotal to the process. This monograph reports on the progress of this family-professional partnership initiative. Following the preface, the first section defines family-centered interprofessional collaboration as diverse health, educational, and social services practitioners working together to improve community-based services for young children and their families. The next section outlines seven principles of this collaboration, several include: recognizing and respecting the knowledge, skills, and experience that families and professionals from all disciplines bring to the relationship; recognizing that negotiation is essential in a collaborative relationship; and bringing to collaborative relationships the mutual commitments of families, professionals, and communities to meet the needs of children and their families. The third section of the monograph details the Health and Education Collaboration Project and the project's primary training and development site, the community-based Healthy and Ready to Learn Center (HRTL) which provides direct services to families with children (prenatal to age 5) who are at environmental risk. The fourth section describes the project's 2-year implementation. The fifth section details the developmental stages of the project and lessons learned: Stage 1--Building a Shared Vision; Stage 2--Staff Development; Stage 3--Training; Stage 4--Evaluation, Feedback, and Refinement; and Stage 5--Dissemination. Seven practice examples included from the HRTL staff reflect the meaning of the principles of family-centered interprofessional collaboration. Following a summary, three appendices outline other demonstration projects funded by the U.S. Maternal and Child Health Bureau, list the members of the National Commission on Leadership in

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Interprofessional Education (NCLIE), and list HEC Project Advisory Committee Members. Contains 12 references. (SM)

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Building Bridges

Lessons Learned in Family-Centered Interprofessional Collaboration

Year Two

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Sharon Taba
Project Director
Health and Education Collaboration Project

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Preface

Many infants and children are at risk for compromised health and development. Some are at biologic risk, such as those with low birthweight, which increases their risk of developmental delay. Some live in unsafe environments. Neighborhood violence and substandard housing, for example, put children at increased risk for injury. Still others are born to parents whose immaturity, isolation, or poverty make it difficult for them to provide a stable, stimulating, and nurturing home.

Our nation's policy makers and family advocates are gravely concerned by all of these problems. They are doubly challenged, however. First, many families experience an array of interrelated health, social, and educational needs. Second, services addressing these needs are fragmented. In the health system, for example, managed care plans designed to cut high health care costs often impede access for families who need care the most. Welfare reform aims to reduce unnecessary demands on the social service system, but its potential effects on young children are worrisome. Although welfare reform promises to offer child care to welfare recipients, the child care system is not prepared to deliver this care. That system is plagued by a shortage of trained early childhood educators; it is unable to meet current demands for care, particularly for infants and toddlers.

Practitioners, too, are perplexed at the complex problems families face. Practitioners have been trained to fix problems singly. Bound by their systems, practitioners are tied by policies and procedures that prevent comprehensive solutions. Increasingly, they are frustrated, often feeling ineffective in helping young children and families in their care. Pediatricians, for instance, are constrained by the "medical necessity" restrictions imposed by managed care. Social workers bristle when welfare reform dictates work requirements across the board without considering the families' individual circumstances. Early childhood educators clamor for quality child care, but their devalued status impedes public support for a coherent career development system that would provide training and equitable compensation for a quality workforce. Most notably, well-trained collaborative professionals are in short supply.

National and state leaders, practitioners, and families are calling for new approaches to help families, professionals, and systems make substantive changes. School-linked services, full service schools, and one-stop family centers are among many approaches being tested in many communities. The National Educational Goals were designed to reform our school systems. The first educational goal is, "By the year 2000, all children in America will start school ready to learn." Educational leaders also recognize that the health and educational needs of young children are inseparable. To meet these needs, programs serving infants and young children must begin before birth and must provide comprehensive and integrated health, educational, and social services needed to support families with young children.

One promising approach to comprehensive, integrated services is chronicled in this monograph, the second in a series of four. The monograph is the result of a grant from Maternal and Child Health Bureau, Title V, Special Projects of Regional and National Significance (SPRANS).

IN THE U.S.A.:

About **every minute**, an adolescent has a baby.

In 1993, almost **half** of all children could expect to experience a divorce during childhood.

One in four children under age 3 (almost 3 million children) live in poverty.

Nine out of every thousand infants die before age one–a higher mortality rate than 19 other nations.

In 1994, **10 million** children had no health insurance.

3 million children have serious emotional disturbances.

The purpose of this Maternal and Child Health Bureau funding initiative is three fold:

1. to demonstrate the ability of health, social service, and education professionals to work together in communities to foster successful physical, social, and emotional growth for children and their families;
2. to assist in the development of curricula based on best practices learned in community settings; and
3. to disseminate a collaborative model of personnel training and service delivery at the regional, state, and national levels.

The initiative grew out of the recommendations of Healthy People 2000 and the National Agenda for Children with Special Health Care Needs: Achieving the Goals 2000. One of the latter's objectives is to create a collaborative health, education, and human services system for children and their families, particularly those with special needs. In keeping with this national agenda, our Health and Education Collaboration Project (HEC) is developing a personnel preparation model that promotes working relationships among trained collaborative providers and keeps families pivotal to the process (U.S. Department of Health and Human Services, 1996). Along with the HEC community-based project, two university-based programs were funded by the Maternal and Child Health Bureau to target university schools of social work, education, and medicine.

The three demonstration projects are:

- Health and Education Collaboration Project, Hawaii Medical Association. Principal Investigator: Calvin C.J. Sia. Project Director: Sharon Taba.
- Partnerships for Change Project, Department of Social Work, University of Vermont. Project Director: Kathleen Kirk Bishop.
- Higher Education Curricula for Integrated Services Providers Project, Teaching Research Division, Western Oregon State College. Project Director: Vic Baldwin.

To assure broad dissemination, these demonstration projects work closely with the National Commission on Leadership in Interprofessional Education (NCLIE). The purpose of the Commission is to bring the best community-based practices with children and families into University programs. Through a family-professional partnership, the Commission supports the preparation of a new generation of interprofessionally oriented leaders in health, education, and social work who possess the knowledge, skills, and values to meet the needs of all children and families by creating, maintaining, and improving effective community-based integrated service delivery systems.

Purpose of This Monograph: This monograph chronicles the development of a family-centered interprofessional collaboration model. The model calls for new working relationships among families and professionals. The goal is to improve community-based services for young children and their families.

The monograph begins by introducing seven principles of family-centered interprofessional collaboration. It then describes the lessons learned to date in each of the five stages of development and implementation of our model. It concludes by translating the principles of family-centered interprofessional collaboration to actual practice using examples contributed by staff of the Healthy and Ready to Learn Center, our regional community-based site.

What Is Family-Centered Interprofessional Collaboration?

The family-centered interprofessional collaboration model is an approach based on the belief that diverse professionals working in partnerships with families can accomplish more together than they can apart.

Family-centered care refers to care that recognizes and builds upon families' resiliency and strengths to meet their needs and aspirations. Family-centered practitioners respect families' history, culture, language, and practices.

Interprofessional collaboration refers simply to diverse professionals working together with families to benefit families. Interprofessional practitioners must develop trust and acquire a healthy respect for other professionals. They, too, respect one another's history, culture, language, and practices. Interprofessional collaboration is not an end in itself. It is an approach for helping families to accomplish their personal goals in a comprehensive and integrated way.

Family-centered interprofessional collaboration is the special care that professionals and families offer to one another that enables all to identify, understand, and reach goals that ultimately benefit the child and the family.

Seven Principles of Family-Centered Interprofessional Collaboration

The Health and Education Collaboration Project is working on a model of personnel preparation and service delivery that is based on family-centered values and extensive interprofessional collaboration. As part of this effort, project staff have developed a set of principles of family-centered interprofessional collaboration drawn from two sources. First, we have adapted the principles of family/professional collaboration developed by Kathleen Kirk Bishop, D.S.W., Josie Woll, and Polly Arango and published in the monograph, Family/Professional Collaboration for Children with Special Health Needs and Their Families *(1993). We have incorporated into these principles concepts of interprofessional collaboration developed by Katharine Hooper-Briar and Hal A. Lawson and published in the monograph,* Serving Children, Youth, and Families Through Interprofessional Collaboration and Service Integration: A Framework for Action *(1994).*

Family-Centered Interprofessional Collaboration:

1. Promotes a relationship in which family members and professionals work together to ensure interagency coordination to provide improved services for the child and family.
2. Recognizes and respects the knowledge, skills, and experience that families and professionals from all disciplines bring to the relationship.
3. Acknowledges that the development of trust is an integral part of the collaborative relationship.
4. Facilitates open communication so that families and professionals feel free to express themselves.
5. Creates an atmosphere in which the cultural traditions, values, and diversity of families and professionals are acknowledged and honored.
6. Recognizes that negotiation is essential in a collaborative relationship.
7. Brings to collaborative relationships the mutual commitment of families, professionals, and communities to meet the needs of children and their families through a shared vision of how things could be different and better.

Health and Education Collaboration Background

The Health and Education Collaboration (HEC) Project was created to identify, develop, and promote key aspects of collaborative interprofessional practice for training. The community-based Healthy and Ready to Learn Center (HRTL) is the primary training and program development site for the HEC Project. HRTL provides direct services to families with children (prenatal to age five) who are at environmental risk. These services include prenatal and postpartum care, routine well-child care, child development information, parent-child activities, supportive counseling, and referral services.

Proponents of collaboration first envisioned the concept for HRTL in 1992 and for the next two years played an integral role in seeing that concept become reality. Developers of the HEC Project were also responsible for HRTL program development at all levels. This included building the initial coalition of supporting agencies as well as hiring and training HRTL personnel.

HEC staff are responsible for ongoing HRTL staff development to assure that center services are provided within the context of family-centered interprofessional collaboration. Thus, the two programs work hand-in-hand to assure that families have access to an array of services that are delivered in a caring and coordinated manner.

HEC brought together a consortium of sponsors for HRTL that includes five primary supporting agencies. A brief description of their roles is listed below.

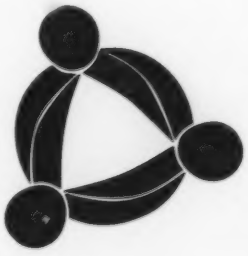
Consuelo Zobel Alger Foundation. The Alger Foundation, which is the operating foundation for HRTL, manages the program. Their eight-year budget includes the cost of facilities, construction, and operations. The Foundation, headquartered in Honolulu, operates 44 programs in the Philippines and five in Hawaii and focuses much of its work on child abuse prevention and amelioration.

Hawaii Medical Association (HMA). HMA, a professional physician organization, is responsible for HRTL development and administration.

Kapiolani Medical Center for Women and Children (KMCWC). KMCWC, a teaching hospital, provides preventive health services which include physician coverage and staffing of a nurse practitioner and a medical receptionist/billing clerk. KMCWC also provides equipment and supplies for clinical services. The administrative staff and departments have donated many hours to planning and implementing these services.

University of Hawaii John A. Burns School of Medicine, Departments of Pediatrics and Obstetrics-Gynecology. The School of Medicine Chairs of the Departments of Pediatrics and Obstetrics-Gynecology have assigned faculty and residents to HRTL for a family-centered interprofessional practicum within their clinical rotations.

Child and Family Service (CFS). CFS, the largest private social service agency in Hawaii, is planning to open the first comprehensive family center on Oahu where HRTL will be housed in the future. CFS started construction of the family center in early August 1996 and will become the permanent administrative agent of HRTL in 1998.



Implementation of Family-Centered Interprofessional Collaboration

Year One

Although there has recently been a groundswell of support for the idea of interprofessional collaboration, few programs have actually translated the philosophy into direct service. Much must be done in order to bring the collaborative philosophy into a working reality. Families, professionals, and institutions must develop new relationships that allow them to work together in unprecedented ways. Old assumptions must be challenged and changed, and new partnerships must be forged to foster new ways to share resources and enhance services.

During the first project year, HEC staff worked with HRTL sponsors and staff to identify and implement key elements of collaboration. In addition, HEC promoted integrated services within the community serving young children and families.

HEC staff found that collaboration was often difficult. It required that individuals change the way they were used to thinking and behaving. The requisite changes were both revolutionary and evolutionary. The revolution largely involved changing convention-bound policies and procedures. Administrators and program planners were asked to challenge traditional practice by abandoning conventional lines of power and turf in order to reduce duplication and to pool resources. The evolution occurred over time as administrators and professionals struggled to implement a collaborative philosophy in day-to-day activities at HRTL. Professionals were trained in the skills of collaboration and used these skills to develop new ways of working together. The first project year was a learning experience for everyone involved, and staff learned through successes as well as failures. The monograph, *Building Bridges: Year One*, outlines the initial stages of development of the family-centered interprofessional collaborative team.

Year Two

The past year has been equally formidable for HEC and HRTL staff. Within HRTL, interprofessional staff have been challenged by the many levels of service and training required to implement family-centered interprofessional collaboration. HEC staff worked with them to clarify their roles and expectations. At the community level, HEC and HRTL staff strengthened their relationships with University programs in pediatrics, social work, and early childhood education. In addition, as trainers, the HRTL staff piloted the pediatric training guide developed by HEC staff. At the national level, HEC staff evoked interest in the HRTL experiences by presenting this model to key government, philanthropy, and university audiences.

HEC learned that family-centered interprofessional collaboration is provocatively complex. These collaborations must consist of collections of people committed to working together and must consider families' preferences and concerns. These

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collaborations must be advanced by seasoned professionals yet embraced by students. And finally, these collaborations must be initiated by individual communities yet sanctioned by state and federal policies. Hence, actualizing family-centered interprofessional collaboration can be a lofty endeavor. ***Building Bridges: Year Two*** chronicles the next developmental phase of the family-centered interprofessional collaborative team at HRTL. It is hoped that the following will provide practical guidelines for others interested in family-centered interprofessional collaboration as a viable approach to helping families.

Healthy and Ready to Learn

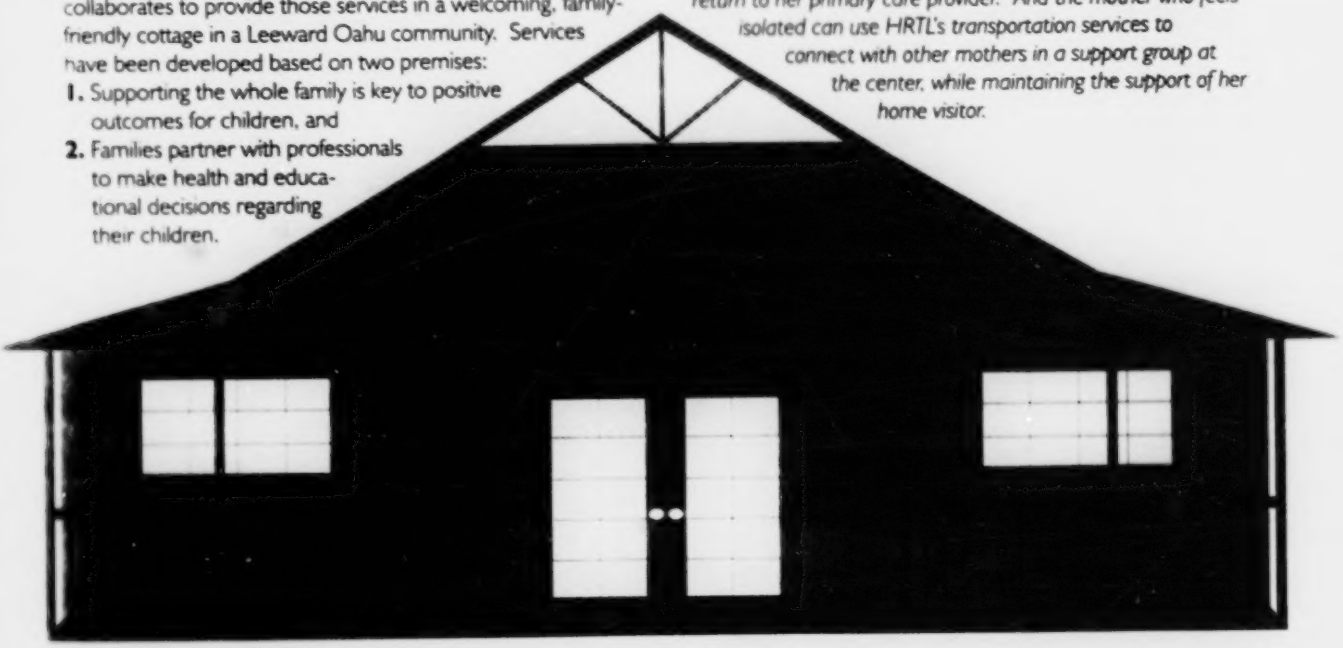
A community pediatrician sees a teen parent whose three-year-old son will not speak during an office visit. An ob-gyn is concerned about a pregnant woman whose health insurance has been cancelled and who therefore cannot afford to continue her prenatal care. Another parent tells her home visitor that she feels isolated at home all day, every day with her newborn child.

The Healthy and Ready to Learn (HRTL) Center was designed to help families and professionals in these situations. HRTL was developed to assist parents under stress with the services needed for their children from birth to five. The program provides health, education, and social services to pregnant women and families with children at risk of poor health or school failure primarily due to negative environmental factors (for example, teen pregnancy, poverty, substance abuse). A nurse practitioner, social worker, early educator, program director, medical receptionist, and part-time van driver form the interprofessional team which collaborates to provide those services in a welcoming, family-friendly cottage in a Leeward Oahu community. Services have been developed based on two premises:

1. Supporting the whole family is key to positive outcomes for children, and
2. Families partner with professionals to make health and educational decisions regarding their children.

Therefore, HRTL offers a range of services for the whole family from which families can choose, including developmental assessment, immunization, adult education, parent support group, parenting class, playgroup, health screening, prenatal/postpartum care, social service, early education referral, and some transportation. Furthermore, HRTL is designed to strengthen connections and fill gaps between other services in their community to ensure seamless care for families.

The pediatrician who is concerned about the three-year-old boy who won't talk can refer the family to HRTL for observation in a playgroup; HRTL's early childhood educator can then recommend to the family and pediatrician more language stimulation or, if necessary, further evaluation for a speech delay. HRTL can provide temporary prenatal services to the pregnant woman with no health insurance; at the same time, HRTL staff can assist her with enrollment in Medicaid so that she can return to her primary care provider. And the mother who feels isolated can use HRTL's transportation services to connect with other mothers in a support group at the center, while maintaining the support of her home visitor.



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Developmental Stages and Lessons Learned

When developing this family-centered interprofessional collaboration approach to solve common problems–children's poor health and school failure–questions often arise around where to begin. The following section describes five stages in the development of the HRTL model. While these stages usually follow in sequence, some may occur simultaneously or out of sequence. Our experience also shows that a particular stage may be revisited and that stages vary in duration and intensity.

Five stages of development laid the groundwork for this new approach to service integration:

1. **Building a Shared Vision**
2. **Staff Recruitment and Development**
3. **Training of Students**
4. **Evaluation, Feedback, and Refinement**
5. **Dissemination**

Building a shared vision establishes the purpose and direction of the program. It includes a solid program design from which staff develop concrete program goals and objectives. Recruiting staff who are comfortable with change and developing their knowledge and skills as members of a team is a key step in operationalizing program design. Training of students galvanizes this new way of working together and perpetuates family-centered collaborative programs. In turn, students spark dialogue, keeping staff focused on actualizing the Center's mission. Evaluation and feedback help staff reflect, assess, and adapt the program to meet desired outcomes. Lastly, dissemination promotes the collaborative message and attracts philanthropic and governmental audiences who find value in contributing to and sustaining such an approach.

During the second project year, HEC staff progressed in all five stages. HRTL sponsors and interprofessional staff reshaped the vision and mission in Stage 1. In Stage 2, staff development jettisoned to the top of the program agenda. HEC developed a training guide for HRTL staff as trainers in Stage 3; this training reinforced HRTL staff's own learning of collaborative practices. In Stage 4, the evaluations recommended that HRTL staff decrease their service area and improve their collaborative practice and training to better serve families. In Stage 5, the collaborative message reached powerful leaders in health, education, and family support through legislation and public/private partnership conferences. The following describes the progress in each stage and the lessons learned in 1995-1996.

Stage I:
Building a Shared Vision

Identifying a shared vision is the foundation of collaboration. What is a shared vision? It is a picture of the future (healthy children who are active learners) seen collectively by a group (professionals integrating services). In the second project year, what moved HRTL staff and sponsors toward a shared vision was defining their program goals and clarifying individuals' roles and responsibilities. Staff grappled both with the vision and with the reality of implementation. Individually and as a team, they came to see families as collaborators instead of recipients and to see themselves as "collective consultants" instead of "isolated experts."

HEC staff learned four lessons in building a shared vision: 1) Start small; 2) Base collaboration on ***mutual*** trust and respect; 3) Build resilient relationships across service networks; and 4) Work both from the bottom-up ***and*** from the top-down.

Lesson 1: Start small.

Begin with the individual, working in a team, within a small community. Each individual must learn what family-centered collaboration is and commit to it. Each must realize that collaboration challenges personal attitudes, values, and beliefs. It taxes the individual's time, sometimes demanding intense discussions about how to make it work. Family-centered collaboration challenges the professional to focus on strengths rather than problems. The professional must learn to see a family as a group of persons whose privacy must be honored and whose time must be protected while meeting the needs of the child and family.

To become a team, professionals and families must understand their individual roles. Each member is expected to contribute his or her discipline-specific perspective to the team while considering the family's goals and objectives. By focusing initially on a few families, team members can develop the methods and tools of working collaboratively on a small scale. As the number of families increases, so, too, does the array of services they desire. HRTL staff found that they could more easily respond to the ideas of a few families. Based on the families' requests, the team together established playgroups, parent support groups, and parenting classes. The team also found that limiting the groups and classes to approximately six to ten families at any given time encouraged friendly interactions and created a comfortable atmosphere where families felt safe.

Even within a small community, HRTL recognized that service integration involves many other community providers and requires good communication with them. It is essential to develop and maintain relationships with other programs. HRTL staff continually test methods to communicate effectively with programs providing health services, family support, and early childhood education. One method is the "Today's Visit" form. When a family visits the Center for a health care visit, the "Today's Visit" form is completed and, with the family's consent, faxed to inform their other service providers. These may include the family's community pediatrician or obstetrician, prenatal visiting nurse, family support worker, early intervention care coordinator, or Head Start teacher. Therefore, families will not have to repeat what happened at the HRTL visit with other community providers. Establishing a working relationship and linking families with other professionals make collaboration with a community a *reality*.

What does the HRTL collaborative envision for the future?

The Healthy and Ready to Learn program envisions communities throughout the world where families have children who are ready to maximize their learning upon entering their educational system.

Ready to Learn means that children up to five years old are stimulated, mentally challenged, emotionally adjusted, and developmentally on target so that they maximize the benefits of their formal education system.

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In achieving their vision, what is the mission of the HRTL collaborative?

The mission of HRTL is to:

- Assess, plan, facilitate, provide, and integrate health, education, and human services for families with high risk preschool children.
- Integrate with other existing programs as necessary; develop programs if needed while avoiding duplication of, and competition with, these programs.
- Promote and advocate collaboration among professionals of health, education, and human services in applying the holistic preventive approach for family wellness.
- Assure the sustainability and replication of the HRTL program.

Starting small helps keep staff, families, and other providers from being overwhelmed by the exponential nature of collaboration.

Lesson 2: Collaboration must be based on *mutual* trust and respect.

Mutual trust and respect are cornerstones of collaborative relationships. When there is *mutual* trust and respect, individuals can depend on one another. Collaborative relationships are interdependent, with each individual working to create a safe environment for honest expression of ideas and feelings, and where each individual is physically and emotionally available to solve problems as a team member. When individuals come together with trust and respect to solve problems interdependently, these collective opportunities provide for perhaps better and more creative solutions.

Family-centered collaborative relationships are differentiated from other relationships by their mutuality. First, some "professional helper-client" relationships are unidirectional–professionals help clients without the expectation that clients help themselves (for example, soup kitchens, food banks). Then, in "parent-professional partnerships," Carl Dunst notes that the helping professionals expect to support and facilitate families' abilities and strengths in seeking solutions to their problems. Finally, "family-centered collaborative relationships," which are similar to partnerships, are *optimal* because they are "complementary, joint, and reciprocal" (Dunst, 1990). That is, professionals and parents establish the mutual trust and respect, mutual support, and mutually agreed upon goals which characterize collaborative relationships. ***Mutuality defines truly collaborative relationships.***

The HRTL staff learned that developing collaborative relationships among themselves and with families takes time; these relationships must grow in secure environments and require open and honest communication. Family-centered collaborative relationships enable families and professionals to take risks together in order to accomplish extraordinary goals.

Lesson 3: Build resilient relationships across service networks.

To help families reach their goals, providers must be skilled at building relationships with families and their other service providers. These relationships must be resilient, able to withstand the changes that occur within and among families' networks. The professional's primary goal is to recognize families' informal and formal networks and to use both networks effectively.

Learning about the informal networks is just as important as learning the formal ones. Once collaborating professionals learn about a family's unique network of contacts, resources, and information, access to services can be easier. For example, a collaborating professional might learn of a neighbor on whom a mother relies for child care. The professional could ask the mother if this neighbor might be willing to watch her other children while the mother takes her baby for overdue immunizations. When professionals learn about these informal relationships, it enhances their network repertoire. Families who share information on these informal relationships trust that providers will not intrude but honor such relationships. When trust is established,

families implicitly rely on professionals to respect their right to decide whom they want to be involved and when and how they want their involvement. Both families and professionals benefit when they share their fund of information and resources.

Collaborating professionals must also be skilled at building resilient relationships among themselves. Professionals can advocate best for improving quality in health, child care, or family support when they understand one another's perspectives. They enable themselves to cross professional boundaries and become staunch supporters of medical homes, quality early childhood education, and family-centered care.

Philippe Gross

The HRTL staff learned that a trusting community of providers can open an array of human and financial resources to their families. This increases HRTL's capacity to facilitate the coordination between the family and their medical home (primary care pediatrician), their family support worker, or their early childhood teacher. Promoting collaborative relationships may require joint office visits with the family and professionals. When a family chooses the HRTL early childhood educator to accompany them to a pediatrician visit, for instance, the early educator may feel that the HRTL nurse practitioner can better suggest pertinent questions to ask the doctor. So she suggests that the nurse practitioner come along. In doing so, the early educator promotes the relationship among the family, the physician, and the HRTL nurse practitioner. Once these relationships are established, services can be better coordinated among the family and professionals.

Again, caution is advised as these relationships develop. Collaborating professionals may inadvertently encroach on one another's turf. At first, these fragile discipline-crossings must take into account the comfort levels of each member entering these collaborative relationships. Professionals may be protective of their families and may not trust one another to care for their families as well as they can. Once collaborative relationships between professionals withstand the tests of time and change, these relationships become resilient to snags and reinforce stronger bridges and safer discipline-crossings.

Lesson 4: Work both from the bottom up *and* from the top down.

Multilevel buy-in is essential to collaboration, yet varying levels of commitment to collaboration by the sponsors and collaborative staff must be expected. Sponsors can best support collaborating professionals by clarifying the lines of authority, responsibility, and accountability. Sponsors must be willing to share the creative power as much as the

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staff must be willing to accept it. Then, as sponsors and the staff develop mutual trust and understanding through their work together, the team and families can better empower themselves to meet the families' needs.

Philippe Gross

At the top level, HRTL sponsors envisioned a comprehensive program and hired staff to implement the program and to develop achievable goals and objectives. However, at the HRTL staff level, it proved unrealistic to expect that the implementation of a broad vision would comfortably emerge from a newly-formed team. The HRTL staff were charged with developing collaborative services for families, scheduling training for students, and learning an entirely new way of working together. Because of the magnitude of these competing priorities, the staff felt unprepared to meet these responsibilities and questioned the viability of the vision.

The collaborative process is humbling. Letting go of program control within and between levels is difficult. Collaboration requires reaching agreements, but if they are reached too hastily or too politely, they are empty agreements. HRTL staff learned that time and energy must be devoted to identifying expectations and exploring differences. Often times, though the administrative sponsors had difficulty *giving up* control, the staff were equally reluctant to *take* control. Sponsors must support collaborative staff by building rewards for collaborative work into administrative policies. Too often, administratively, rewards are directed toward individuals rather than the team. Real collaboration-building begins when collaborators at all levels realize that they must allow one another permission to be, to act, and to be rewarded for their collaborative results.

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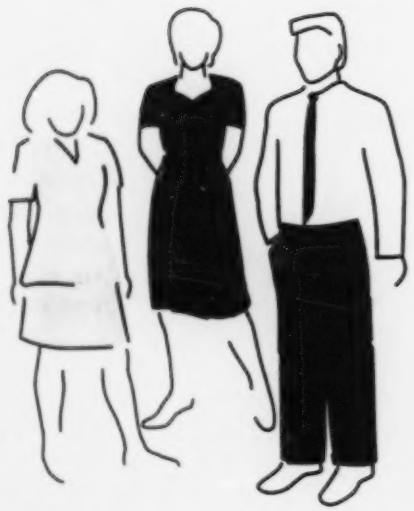
Stage 2: Staff Development



Ongoing support for staff development contributes to the continued growth of staff. To be effective, the leader and collaborating professionals must be accountable for programs that are time-efficient, cost-effective, and driven by results. To accomplish this, the collaborative team must have good communication and negotiation skills. Individuals must strengthen in themselves those personal characteristics that make collaboration possible. In collaboration, everyone must have a leadership role; at the same time, that role must be clearly defined.

HEC is learning that there exist a high risk of failure and a high potential for success when implementing family-centered collaborative practices. Collaborative practice goes against the grain of discipline-specific hierarchical systems. However, if new collaborative projects recognize the importance of leveling the playing field in ongoing staff development, there is a high potential for success.

HEC learned four lessons in staff development: 1) A leader must not let the team lose sight of the purpose; 2) Collaborating professionals must be competent, seasoned, and comfortable with ambiguity; 3) Collaborating professionals teach other team members what they are doing and why; and 4) Above all, collaboratives must develop a team of leaders.

Lesson 1: A leader must keep the team focused on its purpose.

"Leadership is always dependent on the context, but the context is established by relationships we value."

–Margaret Wheatley

It is a myth that collaborative ventures assume that all members are equal. A designated leader is essential to establishing purpose, creating an innovative-thinking environment, and producing a result-oriented performance program. The leader also ensures the development of a solid program, identified by realistic goals, objectives, and "high team performance" (Katzenbach & Smith, 1994). The leader has a dual purpose: to convey a strong belief in a meaningful purpose (improved children's health and education outcomes) and to set the direction with the team.

What must the leader do? First and foremost, a leader must keep the team focused on its purpose throughout the peaks and valleys of program implementation. The value of collaborative results as opposed to individual ones must be widely endorsed. A good leader works through the difficult collaborative issues–personality conflicts, miscommunication, time crunches–and facilitates service improvements by constantly focusing staff on the purpose. A good leader also ensures that opportunities to cultivate staff's understanding and implementation of collaboration are built into program activities.

Second, a leader must create an innovative-thinking environment. He or she must foster team commitment and belief in its ability to initiate programs. High energy and enthusiasm are vital to keeping program activities collaborative. Most of all, a leader is

> ***If you have built castles in the air, your work need not be lost; that is where they should be. Now put the foundations under them.***
>
> ***– Henry David Thoreau***

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available to staff members as necessary. In a collaboration, a true leader transcends professional boundaries and can say, "I'm here whenever you need me" (Butler, HRTL Structured Interview, 1996).

Third, a leader elicits a result-oriented performance from the team. The leader is a role model, achieving the necessary results to assist the team in their work. When results are positive, the leader and the team celebrate their progress together. When the team is discouraged, the leader instills a "can-do" attitude to bolster confidence. Similarly, he or she helps the team eliminate barriers by intervening in escalating situations that undermine team progress.

In essence, the leader helps the team recognize their different levels of expertise, focuses on working together, and encourages result-oriented performance that fosters innovation and risk taking.

Lesson 2: A collaborative person must be competent, seasoned, and comfortable with ambiguity.

"Most powerful is he who has himself in his own power."

–Seneca

Staff attributes may enhance or hinder the success of such a collaborative model. HEC learned that to enhance success, collaborative persons must be technically competent, well-equipped with professional knowledge, skills, and values. The pediatrician diagnoses effectively and prescribes medical treatments. The nurse practitioner examines with care and promotes wellness. The early childhood educator teaches very young children through play. The social worker counsels clients and coordinates with other service providers.

Keely Luke Photographie

A collaborative person must also be innovative, introspective, and willing to take risks. Usually, seasoned professionals have developed a strong enough sense of self to withstand the turbulence of collaborative ventures. At the same time, it is also the seasoned person who realizes that collaboration is not always the best solution for all situations. Knowing when collaborative practices are appropriate and when they are not separates those who are successful and those who are not.

Since a collaborative is inherently difficult to explain, the HRTL staff must be flexible, comfortable with ambiguity, and insatiably open to communication (Duggan, HEC Project Evaluation, 1996). Collaboration requires a person to define and redefine with others the collaborative service, while keeping the needs of families central to their work. Staying abreast of fast-emerging knowledge, synthesizing this knowledge with other

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team members, and creating collaborative solutions in practice foster better understanding of collaboration.

What hinders success are collaborating professionals who are not comfortable with ambiguity and who feel out of control. Because collaboration can be frustrating, there is a natural tendency to control or to withdraw when situations call for group decision-making. This tendency is more pronounced in those who fear failure, lack sensitivity, are overly sensitive, or lack patience. For example, when a pediatrician sees a parenting teen and her unusually quiet child in his office, the professional tendency is to refer the teen to the social worker. However, in a family-centered collaborative center, because he understands the contributions of the other professionals, the collaborating pediatrician does not try to take control and dictate to the teen what to do. Instead, the pediatrician recognizes not only the social worker's ability to counsel the teen, but also the early childhood educator's ability to suggest child activities, and the teen's ability to decide what she wants. Collaborating professionals like these enhance successful collaboration by persisting with communication and decision-making and by negotiating for time and attention with the professionals and families as necessary.

You can't let your differences blind you.

– Blanche Butler, HRTL
Medical Receptionist

Lesson 3: Teach other team members what you are doing and why.

Diverse professionals working in the same setting may not understand the value of one another's perspective, training, and approach. HRTL learned that collaborative centers are natural teaching environments for professionals to learn about each other. The nurse practitioner may learn about how a child learns in playgroup, while the social worker may learn the importance of a well-care visit. It becomes an "osmotic" collaborative experience, thus increasing each professional's ability to learn from the others.

Collaborating staff must consciously demonstrate what they are doing and why. The social worker, for instance, while doing an intake on a family, relies on asking the adult for information, whereas the early childhood educator focuses on observing the child for information. To learn about the child's development, the social worker may rely only on the parent's assessment. The early educator, noticing that the child speaks little, may invite the child to play so that the child's language can be assessed through observation; then she might recommend evaluation. The social worker may later ask the early childhood educator about his or her recommendation. These questions may cause some discomfort, even irritation. It is important to state up front to the other professional that these inquiries are not to question professional competence, but to seek a collective understanding; this will defuse defensiveness. Also, it's important to repeat new knowledge in a variety of different ways–verbally, in writing, by demonstration, or by example.

Collaborating professionals need to be keen observers and must ask questions about the rationale for the others' practices. This means asking the physician, "What is a medical home?" and asking the early childhood educator, "What is developmentally appropriate practice?" Such questions cause professionals to pause and reflect. Working alongside one another reinforces learning and increases collaborative understanding to help the family (Lawson & Briar, 1994).

Lesson 4: Develop a team of collaborative leaders.

"We came on different ships, but now we are all in the same boat."

– Anonymous

Traditional leadership is based on the assumption that decision-making resides with a higher authority. Unlike traditional leadership, a team of collaborative leaders finds solutions from within. It is the ability to set ego aside and understand the other's perspective in order to overcome conflicts and integrate services that reflects true interprofessional practice. Unlike the traditional leader-follower relationship, collaborations share the leadership role, rotating it among the team members. As leaders, team members feel individually responsible and mutually accountable for results.

Philippe Gross

A collaborative team must be extraordinarily clear in delineating how members' roles and expectations intersect. In collaboratives, the leadership roles of members are not easily defined. For example, it was unclear to HRTL team members when to take the lead or follow the lead. Over time, they grew to understand their roles as directors and supporters. As directors, they were in charge of their specialty area, for example, medical director of a health clinic, director of a child care center, or supervisor of a social service department. The HRTL team devoted many hours to clarifying their goals, roles, and expectations as leaders. First, they examined the HRTL strategic plan and the HEC Project materials on interprofessional collaboration. They regularly reviewed their process at staff meetings, quarterly retreats, and informal talk sessions, often engaging in heated, soul-searching discussion. During this process, they learned about reaching consensus, recognizing their strengths and abilities, accepting their shortcomings, and improving outcomes jointly. These were primary tasks in delineating their roles.

In collaborative leadership, the challenge is to balance the expectations of the team with those of the individual. A team of collaborative leaders acknowledges that the job can go beyond the traditional 8 a.m. to 4 p.m. workday and aims at the higher standard of care of their combined professions. These leaders are reminded that their collaborative practice is not an end in itself, but a means to assist families. It may be more satisfying for a nurse practitioner to offer health clinics five days a week than to participate in playgroup with the early childhood educator. However, the essence of collaborative leadership is staff's ability to suspend their professional tendencies, moving away from independent practice and moving toward integrated practice.

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Stage 3: Training

Education about collaboration will help break down the walls and boundaries that professionals have built around themselves and their professions.

–Elsy Kaina, Nursing Student

Community-based models of collaborative training are highly recommended for pre-service and in-service professionals, but can be difficult to develop (Patterson & Blum, 1993). The trend toward incorporating medical education programs in community settings has been especially challenging at both the residency and continuing medical education levels. However, our local university programs met these challenges head on and worked with HEC and HRTL to create resident rotations and a social work practicum tailored to the HRTL Center.

During the second project year, HEC progressed further with both the University of Hawaii pediatric residency program and the social work program than with the ob-gyn residency program. Five modules were developed to teach residents the importance of working with families as partners and the importance of coordinating support services with other professionals. Amid many obstacles (for example, residency requirements, managed care, University budget cuts), the University Department of Pediatrics, directed by Chair, Sherrel Hammar, M.D., continued unwavering commitment to training and service at HRTL. Louise Iwaishi, M.D., Director of the University pediatric residency program, spent many hours reviewing the content of the HEC training. As trainers, HRTL staff piloted the HEC training guide, supplemented by a compendium of articles developed in year one. Mentored by a pediatric fellow, first-year residents participated in a four-week, one-day-per-week resident rotation. The rotation consisted of two full and two half days at HRTL and two half days visiting a family and an infant development program. During the residents' stint at HRTL, they participated in pre- and post-conferences regarding children and families in playgroup and parent support group activities. They also learned concepts of family-centered interprofessional collaboration from HRTL staff. By participating in and visiting community-based programs, residents had first-hand opportunities to experience interprofessional teaming in action.

In addition to pediatric residents, a first-year graduate student was placed at HRTL by the University School of Social Work for a two-semester, two-days-per-week social work practicum. HEC is currently working with the HRTL social worker and student to develop the training and to explore the possibilities of integrating the social work practicum experience with the pediatric community integration experience.

The following are the lessons learned in training students: 1) Training must be integrated into service; 2) Training should value the lessons students teach professionals.

Lesson 1: Training must be integrated into service.

Community-based education, which brings diverse professionals and students together to solve "real world" situations, will better equip pre-service professionals to provide effective services to families and their children (Bailey, 1996). Thus, training and service delivery are interdependent, and both are required to sustain community training and service sites such as the HRTL Center. The underlying assumption is that training and service are interlocking parts that support each other.

A dilemma arises when staff are challenged to serve families and teach students at the same time. Quality child and family service is the heart of all service programs. Balancing family services with the learning needs of students is tricky. Designing a clinical practicum while implementing collaborative services to families has not been easy (Lawson and Hooper-Briar, 1994).

Keely Luke Photographie

Our experience weaving pediatric training with family service illustrates this challenge. HEC centered its pediatric collaborative training around HRTL well-care clinics. Residents spent their days first, learning the importance of collaborating from HRTL staff, second, visiting a family or an early intervention program, and, third, seeing patients for well-child care. This rotation schedule posed service and training conflicts for the HRTL team, the University residency faculty, and the HEC staff. From the service perspective, a family-friendly pediatric clinic should be scheduled consistently on the same day and time and staffed by one person at the convenience of families. Throughout the year, University faculty and HRTL staff tried to work within their program structure to best use resident services for clinic days. Constantly rotating residents disallowed health care continuity with families (that is, they saw a different physician at each visit). From the university perspective, the one-day-a-week clinic provided limited flexibility for resident placement.

At the same time, the University ob-gyn resident program solved this continuity problem by placing one fourth-year resident at HRTL for the whole year. However, this solution benefited only one ob-gyn resident and did not make sufficient impact on the resident program as a whole.

HEC, HRTL, and University faculty solved the dilemma of their competing training and service goals by designating the HRTL nurse practitioner to be the consistent health care provider and coordinator with the medical home. This allowed residents to be trained in other teaming activities which involved the other HRTL interprofessional staff. Having residents work alongside staff helped reinforce the importance of collaboration in their work with families which enhanced, rather than compromised, HRTL's service and training.

Lesson 2: Value the lessons students teach us.

It's good to put yourself in another's shoes (even if they don't fit so well) and see things from the other person's view.

–Mark Haubrich, Pediatric Resident

Learning is a dynamic process among families, professionals, and students alike. Professionals need families and students to examine their practices and ask the hard

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questions. Practicing professionals often are lulled by their daily practice. They may welcome students reawakening their professional dedication with their presence.

We learned the following lessons from pediatric residents at HRTL. Residents had early assumptions about nurse practitioners, social workers, early childhood educators, and families. Most residents were satisfied with the training and brought "new" eyes and ideas to the collaborative experience; the learning between practicing professionals and those in training is multi-directional (Wakatsuki, HRTL Structured Interview, 1996). The residents' own professional identities are "in utero"–still forming. Their exposure to other professionals broadens their beliefs and attitudes toward other professions. They appreciated the knowledge, skills, and values of the other professionals at HRTL. Not surprisingly, most residents were unaware of the contributions which early childhood educators make to families and interprofessional interactions; perhaps this is because residents do not normally interface with educators. Residents told us that the medical home, the importance of early childhood education, family-centered care, and interprofessional collaboration were new concepts to them. Notably, the residents did not seem to view themselves at the top of the professional hierarchy in a community setting. However, they did have early assumptions of the nurse practitioner as assisting rather than working side-by-side with them. We also learned that knowing about community resources continues to be important to them. Finally, we learned that residents wanted training extended to other professionals so that others may also help advocate for medical homes and collaboration.

HEC also learned that the concept most unfamiliar to pediatric residents is that of family-centered care. Perspectives from the residents on family-centered care indicated that the concept needed to be clarified and reinforced. One resident asked, "What is meant by letting the family call all the shots? I don't agree that they should solely make the decision. Neither do I agree that most families want to be partners in health care." Certainly the residents' discomfort with families in new, more powerful roles may create ambivalence, resistance, and sometimes anger. It may reflect giving up a certain amount of control in the traditional sense.

Integral to student learning is their ability to relate theory to practice. Heavy responsibility lies upon site instructors to make the link between the two. The instructor must keep abreast of the current literature and professional standards and ethics, structure student practice in support of families and collaborating agencies, and use Socratic methods (the art of questioning) with the resident. Students' ability to think critically, to ask questions, to assess situations from multiple perspectives, and to plan alternative actions in actual practice is critical to the students' learning and to those professionals who teach them (Beckman et al., 1996).

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Our greatest glory is not in never failing, but in rising up every time we fall.

– Confucius

Stage 4: Evaluation, Feedback, and Refinement

The purpose of evaluation, feedback, and refinement is to promote achievement of service and training goals. Monitoring a constantly evolving entity requires recording individual and collective perspectives on successes and failures. Varied data collection methods and measurement tools are needed to track the development of collaborations in ways that are useful to key players (Knapp, 1995). At the outset, observing and asking families, interprofessional staff, and community providers about what they do and how they do it creates baseline information from which a collaborative program can make changes.

The one important lesson we learned from evaluation was to clearly define useful outcomes. We defined useful outcomes for both the training and service components at the HRTL Center. Described below are evaluations in two arenas: training and service. The training evaluation was conducted by Anne Duggan, Sc.D., from Johns Hopkins University in Baltimore, Maryland, and the service evaluation was conducted by Robert W. Heath, Ph.D., from the University of Hawaii. Because of the difficulties in evaluating collaboration, the most useful questions to both HEC staff and HRTL staff and sponsors were: What is your understanding of collaboration? How well are collaborative services and training being provided?

Lesson 1: Clearly define useful outcomes.

Evaluation helps "...to share information with staff in a way that can inform its future development."

–Anne Duggan, Sc.D.

Evaluating the program can be as simple as finding what works, what does not work, and how to make it better. Making mid-course corrections based on evaluation findings helps staff feel empowered to deal with the difficult and complex concept of family-centered interprofessional collaboration. It is better to process and assess proximal outcomes of collaboration first (for example, how well are we collaborating?) and then to tackle distal service and training outcomes (for example, school success). Process assessment begins by focusing on key participants–family, staff, sponsors, and faculty–and by ascertaining the congruence of their perspectives–on what family-centered interprofessional collaboration is and how well it fits with their personal goals.

The HEC Training Evaluation. This training evaluation was conducted by Anne Duggan, Sc.D., of Johns Hopkins University.

Dr. Duggan aptly describes the HEC experience as "...building and riding a bicycle at the same time." She conducted a formative evaluation with the purpose of shaping continuing development. Duggan's evaluation is particularly helpful because of its decided focus on the perspectives of many informants. Her primary intent was to inform key players of barriers yet to be overcome in interprofessional collaboration training. To date, data have been collected through interviews with HEC staff, HRTL staff and sponsors, and University pediatric residents, social work students, and faculty.

Initially, Duggan reported that HEC staff must pay close attention to the following: 1) the commitment of sponsors to service and training as a viable model; 2) certain

interpersonal attributes and group skills (for example, team building, conflict resolution, and negotiation) that are likely to contribute to the success of the collaborative process; and 3) university programs that are more likely to hinder than promote successful integration of new training. In the ongoing round of interviews, she is focusing on what students have learned about family-centered interprofessional collaboration, how they would redesign the program to make it more effective, the quality of the collaborative teaching, and how this introductory curriculum can best be incorporated into the three-year pediatric program.

Duggan plans to study further student outcomes and faculty incentives. She will examine how collaborative learning is incorporated in other clinic settings. In addition, she plans to look at what faculty incentives exist to support community-based collaboration. She believes stronger time commitment and willingness to change existing protocols by the faculty must be incorporated if integration of family-centered interprofessional collaboration is to succeed. She notes that some collaborators are not convinced that training is an integral component. She also speculates on whether or not the training and service model will survive as a viable one once the collaborative venture is transferred to its permanent administrative agent.

Her strong recommendation, therefore, is that HEC leaders win over all collaborative sponsors. Ultimately, if this approach is to serve as a prototype for other collaborative ventures, ownership of this approach must be taken by collaborative sponsors.

The HRTL Service Evaluation. The service evaluation was conducted by Robert W. Heath, Ph.D., from the University of Hawaii.

Preliminary findings were promising. What we learned about evaluating service delivery was also challenging. The evaluation focused on answering three main questions: 1) How well are services being delivered? 2) How well are services received? and 3) How well do the staff collaborate with other agencies? Demographic, geographic, and referral source data were collected from the HRTL database, and structured interviews were conducted with families, HRTL staff and sponsors, and HEC staff. Data from families revealed that families were very satisfied with the quality of services provided by a caring staff. Dr. Heath, too, noted the development of interprofessional collaboration was fraught with difficulties, but that staff appeared to have demonstrated new practices in family-centered interprofessional collaboration.

HRTL learned some answers to the key questions posed. In the health area, the quality of medical services delivered was good. However, a question was raised about how realistic the goals of the center were to improve the health status and the education outcomes of children and their families. Heath suggested that services expand in order for the center to meet the above-mentioned goals. He recommended expanding

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Philippe Gross

screening and referral services to include nutrition/dieting and mental health services. In the educational services area, parenting and early childhood activities were "well-received." Families suggested that the program provide more services and more help with transportation, and that these services be scheduled at convenient times (for example, evenings, weekends). In the social service area, although the social worker did intakes and registered clients fairly well, there was untapped potential for doing outreach and advocacy. Heath suggested that the social worker assume a stronger role in the development of family plans and monitoring the progress of those plans. Heath summarized that the three professional staff, "have worked their way to an emerging operational definition of interprofessional collaboration." In addition, to respond to such a unique blend of family and professional needs, the HRTL Center will always be a work in progress.

Stage 5: Dissemination

Making fundamental changes in our system of care requires disseminating the experience of the family-centered interprofessional collaboration approach to national, state, and local audiences. Because of increased national attention turning toward the plight of our youngest children and their families, the time is ripe for family advocates to market effective strategies for change in our systems. In many arenas–maternal and child health, family support, early intervention, and early childhood education–the emerging consensus is that interprofessional collaboration and service integration are necessary to improve services to families. Leaders in both public and private sectors have noted the development of a preponderance of interprofessional collaborative and integrated service models. Development of models in diverse fields continues; the lesson HEC learned this year on dissemination was to target an audience open to collaboration.

Lesson 1: Target your audience.

Heightening awareness of a targeted audience is a necessary first step in changing our health, education, and social service systems. Moreover, the success of the interprofessional collaboration model for improving the conditions for vulnerable infants and toddlers and their families rests on those who have made fundamental shifts in service delivery and training systems: from traditional training to interprofessional training of students, faculty, and practitioners, and from categorical services to collaborative ones.

HEC has targeted specific audiences who have made this fundamental shift in orientation to interprofessional training and integrated service delivery at the national, state, and local levels. At the national level, a cross-cutting conference challenged health, early childhood, and family support experts to support and sustain integrated services. At the state level, a legislative resolution calling for collaboration of departmental initiatives captured legislators' attention as a promising, cost-saving strategy in a tight fiscal year. At the local level, HEC convened a subcommittee of its advisory group interested in piloting a community mobilization planning project for integrated health, early childhood education, and family support services. The following describes HEC's targeted national, state, and community efforts in greater detail.

The most noteworthy national dissemination activity was the conference, "Meeting the Needs of Young Children: Professional and Community Strategies That Work," held in Hawaii in December, 1995. The conference was sponsored jointly by the Carnegie Corporation of New York, the Children with Special Health Care Needs Division of the Maternal and Child Health Bureau of the U.S. Department of Health and Human Services, and the Hawaii Medical Association. National and state participants were

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selected for their expertise in health, early childhood, and family support. These experts reinforced the value of the collaborative message and influenced both state and national leaders. The conference sparked interest in setting a national agenda for developing an integrated early childhood pro-family health, education, and human service system.

Keely Luke Photographie

Another targeted national audience has been the National Commission on Leadership in Interprofessional Collaboration (NCLIE). NCLIE supports the preparation of interprofessionally oriented leaders in health, education, and social work to create an integrated service delivery system. Within the past two years, the NCLIE has dove-tailed its meetings with educator and social worker conferences. In March of 1996, NCLIE targeted the International Parent-to-Parent Conference which convened parents of children with special health care needs. The NCLIE/Parent-to-Parent meeting, held in Albuquerque, New Mexico, encouraged meaningful exchanges among families and university faculty and administrators. Parents impressed on NCLIE members the importance of working with families and other professionals. Parents also stressed the importance of students learning to work with families and other professionals to become effective practitioners.

At the state level, Hawaii legislative leaders were targeted to promote a pro-family service system. Legislators and department leaders, encouraged by grassroots support to coordinate departmental collaboration initiatives, adopted a legislative resolution to pursue the development of this pro-family service system. HEC staff participated in a leadership conference arising from this state resolution. The conference was attended by over 200 family and professional leaders, many of whom were invited to the December 1995 Carnegie/MCHB/HMA conference. The conference not only reinforced the support of families and professional leaders from the three disciplines but also directed the group in gaining legislative support. This event marked the state's commitment to an early childhood pro-family health, education, and human service system. By targeting the state's leadership and gaining legislative commitment, this conference gained strong state support for a collaborative agenda.

At the local level, encouraged by Carnegie's *Starting Points* report and the commitment of Hawaii's departmental leadership to an integrated early childhood pro-family service system, HEC staff targeted a group of interested community leaders and urged them to apply for a Carnegie Starting Points State and Community Partnership Initiative grant. This leadership group from philanthropy, early intervention, family support, health, higher education, and early childhood education constituencies shared their vision of that integrated system. Successfully funded, the Carnegie grant affords us further opportunities to bring the collaborative message to local communities. This public-private initiative is headed by co-principal investigators, Calvin Sia, M.D., of the Hawaii Medical Association and Sheila Forman, Ph.D., of the Governor's Office. Like riding the crest of a wave, these targeted efforts supported Carnegie's national agenda to focus on the needs of our youngest children. Sustaining this momentum now requires increasing support in many communities by calling attention to our youngest children and families.

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Practice Examples of the Principles of Family-Centered Interprofessional Collaboration

Seven practice examples are presented here to illustrate the principles of family-centered interprofessional collaboration (from page 6). The gap between principles and practice can be difficult to bridge. Therefore, HEC asked the interprofessional staff at Healthy and Ready to Learn Center (HRTL), our training and program development site, to provide practice examples that reflect the meaning of these principles in their work with families. The examples attempt to explain what these principles mean concretely; it is from these examples that professionals can test their current practices to truly reflect family-centered interprofessional collaboration.

Some people think family-centered interprofessional collaboration is a good idea. They believe it is an approach that enables families and professionals to negotiate the best services for children. Others are skeptical. They believe it is an approach that hinders both family and professional members because it involves too many people and requires too much time. The following examples illustrate our understanding of the principles and assert that family-centered interprofessional collaboration does indeed improve services to children and families.

Promotes a relationship in which family members and professionals work together to ensure interagency coordination to provide improved services for the child and family.

Practice Example

The following illustrates families and professionals working together to access therapy services. Despite snags at several critical points, the family got early intervention services with the help of the HRTL staff. (Contributed by Katy Cochran, early childhood educator)

When Moana registered for our program, we learned that she had many concerns. She wanted most to find out if her son, Keoni, had a hearing problem and how to get him evaluated for it. We found that Moana was seeing many other service providers–a public health nurse (PHN) for coordination and referral services, a heart specialist for Keoni, a worker from the Women, Infants, and Children (WIC) program, a teacher at a local parent/child program, and the evaluation worker from a local early intervention agency. Since her former pediatrician was not a primary care provider in Moana's managed care plan, the pediatrician could only be available to Moana by telephone.

While attending HRTL playgroup, Moana asked me if I could do anything to speed Keoni's referral for speech and hearing evaluation. I brought this up at post-conference with staff. The HRTL nurse practitioner also reported that Moana told her of Keoni's frequent ear infections and that Moana had asked her to check him during playgroup. The HRTL social worker volunteered to contact her PHN and I spoke to the early intervention agency, H-KISS (an information and referral service) to identify the problem–the delays in getting an evaluation for Keoni. H-KISS responded quickly and asked Moana to choose a care coordinator. The HRTL nurse practitioner worked with the PHN, who knew about Keoni's frequent ear infections. Moana chose the PHN to be her care coordinator; the PHN immediately forwarded a request for his speech and hearing evaluation to Keoni's interim pediatrician at the local medical center's out-patient clinic.

Moana found it difficult to follow-up with the interim pediatrician because the out-patient clinic was far from her home. She told each of us about her difficulty. At our next post-conference, staff explored ways to help her see the physician she had seen previously. The nurse practitioner and I took Moana to the interim pediatrician the next time Keoni had an ear infection.

A month later, Moana called our nurse practitioner about bringing in Keoni again for yet another ear infection. By this time, we were all frustrated by the experience. Learning about our experience with Keoni's inconsistent medical care and our lack of progress in getting the necessary speech and hearing evaluation, Dr. Iwatani, the medical director and University professor who consults with our project once per month, gave Keoni a thorough examination at HRTL. Dr. Iwatani, assisted by a pediatric resident, concurred that speech and hearing evaluation was immediately needed. As part of our HRTL team, Dr. Iwatani expedited the referral by discussing the history and the urgency in a way that only the medical director could. Finally, we were able to pry Keoni from the sticky referral web. I followed up with the evaluation coordinator, with whom a speech and hearing evaluation was scheduled, and also checked with the social worker and the physician about the occupational and physical therapy evaluations which were necessary. Keoni finally got the therapy he needed.

Many like Keoni go unnoticed once it appears they are in the system. The persistence and time it takes to get an evaluation often demand that the family and all the professionals work together to overcome the sloth-like movements of the system. Because HRTL was designed to promote family-centered interprofessional collaboration, the program strongly endorsed the added time and staff support needed to overcome glitches and obtain needed services.

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2 Recognizes and respects the knowledge, skills, and experience that families and professionals from all disciplines bring to the relationship.

Practice Example

The following illustrates how a mother and staff pooled their knowledge and experiences to obtain the multiple services needed. (Contributed by Dianne Wakatsuki, nurse practitioner)

Last year, Nancy came to us because she was 16 weeks pregnant, felt that her pregnancy was high risk, but had no medical insurance. She also talked about needing help for her severely-compromised 2-year-old son and about the impending arrival of her fiancé's two teenage sons, whom she felt would need counseling to deal with the recent death of their mother.

Because Nancy's pregnancy was high risk, finding an ob-gyn was a high priority. I first asked the ob-gyn resident in our HRTL prenatal clinic to follow Nancy until medical insurance could be obtained. As soon as Nancy got insurance, I offered her referrals to obstetricians whom she might like.

Nancy's 2-year-old son, Alton, was born at 32 weeks and diagnosed with bronchopulmonary dysplasia. At 6 months of age, he suffered respiratory arrest and a seizure which resulted in encephalopathy. He then required frequent doses of medication to control seizures and to ward off respiratory infections. Nancy told me she didn't have enough money for the medication and couldn't reach her fiancé who was "in the field" for military maneuvers. We loaned her money from our emergency funds to get the medication that same day.

Nancy had extensive knowledge regarding Alton's condition. She knew how to evaluate his symptoms, when to give medication, and when to begin using oxygen. I asked several local community agencies for assistance in providing Nancy with the supplies needed for Alton's home care.

Over the next few weeks, our whole team came together to help Nancy meet her needs. In addition to HRTL's attending physician providing routine prenatal care, our early childhood educator suggested things Nancy could do with Alton to encourage his development. Our social worker and I helped Nancy fill out insurance applications including a "medical necessity" appeal for quick action to cover Alton.

Once the family was insured, we referred Nancy to a medical home which could see Alton regularly. However, driving to the clinic was grueling as Nancy came closer to delivery, and she again came to us. We found Dr. Norris, a pediatrician close to home, and arranged for Nancy and her public health nurse to visit Dr. Norris. It was important to Nancy that she find the right doctor who would listen to her and answer questions about Alton.

Nancy likes the "Today's Visit"* form that HRTL uses–it helps her keep track of what she needs to do. For instance, Mel, our social worker, gave her lots of referrals for counseling to help her fiancé's sons deal with their mother's death. In addition, the Today's Visit form keeps her pediatrician abreast of her HRTL visits.

Seasoned professionals capable of working in partnership with families promote the very best possibilities for any child, particularly one with special health care needs. Family-centered interprofessional collaboration enables an interdisciplinary staff within a comprehensive program provide services that include all family members in need.

*The Today's Visit form, designed as a collaborative tool, is used by HRTL's pediatric residents, nurse practitioner, social worker, and early childhood educator. Through the use of this tool, families and professionals record what happened during the day's visit, and parents take home individualized instructions from each professional. Held in the strictest confidence and with parental consent, this collaborative form is faxed to other providers (for example, home visitor, physician, and public health nurse), so that families are not burdened with having to retell what happened at the visit.

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3 Acknowledges that the development of trust is an integral part of the collaborative relationship.

Practice Example

The following example demonstrates the development of a trusting relationship which led this parent to develop a plan to reach her goals. (Contributed by Melvin Hayase, social worker)

Gwen was referred to HRTL for playgroup and parenting classes. She was initially sociable, friendly, and easy going, although she was uneasy about leaving her children with anyone while she talked with staff. Despite these feelings, she developed a collegial relationship with staff and others. When HRTL decided to form a parent support group, Gwen was one of the first to join and began to share more consistently her weekly ups and downs and her history of rejection by her mother. She commented at one point that she felt so safe at the Center that even when she fell back to using physical discipline with her children (although she knew that it was not an endorsed method at HRTL), she did not feel rejected by staff and others.

Gwen developed her own network of communication with HRTL. With me, Gwen inquired about financial aid for college, child care, her relationship with her boyfriend, and the life-long conflict she had with her mother. Although she had her own pediatrician, Gwen occasionally consulted with the HRTL nurse practitioner about her children's health status, willingly accepting the nurse practitioner's frequent suggestions to check back with her pediatrician. Gwen developed a more personal relationship with the early childhood educator, Katy, confiding in Katy about her parenting as well as her relationships.

One thing was clear to Gwen: she wanted to return to school when her children were in preschool. In the meantime, she was resigned to staying at home. She shared her dreams and aspirations but expressed that she believed "it was not going to work out." Staff worked with Gwen to delineate her goals in a family care plan. Using the family care plan as a tool for communication, Gwen gained a sense of control in her life. A clearly spelled out, written plan was what she needed to move her beyond HRTL's walls and to make her dreams a reality. The plan was specific, in writing, and required her signature for commitment and verification. The plan included her goal to return to school, defining the necessary steps to meet that goal. In two months, she registered to attend a private technical school, secured funds for her own education, and obtained grants for her children to attend preschool.

Developing trusting relationships with the staff enabled Gwen to share her dreams and frustrations. That was the first step in making her dreams a reality.

4 Facilitates open communication so that families and professionals feel free to express themselves.

Practice Example

The following example demonstrates how open communication led this parent to trying an unfamilar way to achieve her goals. (Contributed by Melvin Hayase, social worker)

Hinalani was a 25-year-old, part-Hawaiian single mother who liked bringing her children, ages 5, 4, and 1, to our playgroup. She applied for welfare assistance and got Aid to Families with Dependent Children (AFDC), food stamps, Health Quest (Hawaii Medicaid program), and WIC. She also received some child support from the father of her youngest child. Hinalani was shy and quiet and described herself as overweight. At times, she said, she rushed out of the house having little time to comb her hair or to straighten her clothes. Her children appeared to be healthy and developing well.

Hinalani liked our staff because she felt that they were not judgmental and that they understood her, even when she felt embarrassed about not giving breakfast to her children. However, at our playgroup, Hinalani felt uncomfortable with the other mothers at first and didn't trust them. I encouraged her to come again for the support group so she could have time to get to know and become comfortable with the other mothers. As she became familiar with each of them through their stories in support group, Hinalani became more talkative.

Hinalani slowly got more involved in our playgroup and support group. I asked the early educator to pair her with another mother during excursions and asked the nurse practitioner to ask Hinalani to make a nutritious chicken dish with one of the newer mothers. As the months passed, she began talking freely with the other mothers; as she puts it, "she's used to them now." She began to feel very confident of herself and was more willing to try new things. She was even willing to work with all the staff on a family care plan (similar to the Individual Family Support Plan), a process unfamiliar to her. She felt accomplished on seeing that it is possible to reach her goals every step of the way. She described this family care plan process as being "more concrete, and that's good."

Encouraging Hinalani in a non-threatening way to communicate with other families and professionals helped her express what she truly felt and wanted to achieve.

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5 Creates an atmosphere in which the cultural traditions, values, and diversity of families and professionals are acknowledged and honored.

Practice Example

The following illustrates a family-centered environment that fosters acceptance of diversity and is responsive to families' needs. This example shows how the staff acknowledged the family's strengths and included the family's preferences. (Contributed by Audrey Ching, program director)

May Li, newly immigrated from Hong Kong, was a quiet person and self-conscious about speaking English. She started coming to playgroup in March, 1995 with her three daughters, ages 6, 4, and 2. She wanted support in dealing with her daughters' demanding behavior. At first, she watched Katy, our early childhood educator, lead the playgroup and saw how other parents and children there play together. She then worked with Katy to understand her daughters' behavior and her expectations of herself as a mother.

May Li learned that her daughters may have been reacting to the problems she had with her husband. She and Katy explored new supportive ways of responding to her children. May Li learned that physical punishment was not her only option; she learned to declare a time out and leave the room to avoid losing her temper and hitting the children.

May Li's problems with her husband, who is Vietnamese and Chinese, began when they came to Hawaii. She realized that he would not change his ways, and she described their relationship as one of physical presence, "We live together, but don't talk to each other." We discussed some options of support from which she might choose. These were a women's support group, counseling with her husband, or a traditional Chinese helper with our social worker. May Li decided to join the support group.

In the support group and other HRTL activities, families are encouraged to share their cultural traditions and values. May Li was both happy and scared when other parents asked her to do a Lunar New Year activity. She was surprised that other families wanted to learn about Chinese families and her way of life. She helped us design the flyer; she wrote a story about how Chinese families get ready for the new year by cleaning, cutting their hair, getting new clothes, honoring the gods, and preparing traditional foods to welcome the new year.

Many parents liked May Li's activity and learned from her story; they told her they wanted to learn more about Chinese traditions. In turn, May Li wanted to learn about Filipino families. May Li was reassured that even though people come from different cultures, they have similar needs. As she learned about other people, she began to understand how she could use their experiences in her own life.

May Li is now attending English classes and looks forward to getting a job and supporting her children on her own. May Li says she benefited from the many people with whom she shared her personal story. They provided consistent positive messages to her as a woman, wife, and mother, newly-arrived from a different culture and adapting to a new one.

Family-centered interprofessional collaboration encourages professionals to honor families such as May Li's and to assist families by acknowledging their cultural richness to share with other families.

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6 Recognizes that negotiation is essential in a collaborative relationship.

Practice Example

The following illustrates the importance of negotiation among a Micronesian family and the HRTL obstetrician-gynecologist resident and other HRTL staff in reaching a mutual understanding as they cross ethnic and professional cultures onto common ground together. (Contributed by Melvin Hayase, social worker)

The ob-gyn resident couldn't understand why Sue, a pregnant teen, kept returning for visits but did not follow his orders. He gave her instructions on each visit, and she nodded as if she understood. Yet every time Sue came back, she hadn't done what he instructed. The resident was upset with her because she wasn't following his orders.

The ob-gyn resident and I started talking about this situation. He felt that Sue was being irresponsible and could not be told what to do. I suggested that we conference with the rest of the HRTL staff. I thought a negotiation conference with the interprofessional team would be an opportunity for the resident and team to share relevant information and concerns about the family. That, in turn, would enable the team to be more sensitive to issues of the family and to deal with them appropriately. Negotiation conferences remind us that our families are in charge of their lives, and, only with their permission, we are simply intermittent helpers to them on their life's journey.

During our conference, the HRTL nurse practitioner shared that she found Sue crying and upset that the doctor did not make her problem go away. However, because English was not Sue's native language, she was unable to tell the nurse practitioner what the problem was. I shared what I had learned from this teenager about herself and her Micronesian family. I learned that her family didn't approve of her taking vitamins or seeing a doctor. However, they did value the time and care given by their cultural healer. With this understanding, we decided to invite the mother of the family to discuss the problem with the ob-gyn resident. The nurse practitioner volunteered to sit with the mother and find out her concerns. We then all sat with the family and the resident and discovered that the teenage daughter was experiencing painful urination. The ob-gyn finally understood what Sue was describing; she had a yeast infection which didn't go away.

Because of the team conference with the family, the resident learned new ways to ask the girl's concerns, and Sue learned what to expect of him. He now coaxes her along and tells her the importance of taking care of herself in ways she understands. He sees it as a new challenge for a better physician-patient relationship. In this way, family-centered interprofessional collaboration helped the resident recognize that the family, social worker, and nurse practitioner can all help each other become better health providers. By agreeing to talk with the family and working to reach an understanding of the importance of prenatal care for a healthy, full-term baby, the resident improved his patient care and Sue's probable outcomes.

The staff negotiating their perceptions of Sue led to more effective interactions between the professionals and the family.

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7 Brings to collaborative relationships the mutual commitment of families, professionals, and communities to meet the needs of children and their families through a shared vision of how things could be different and better.

Practice Example

The following illustrates a community's response to a problem–closing a respite program. Families and professionals in the E'wa district of Oahu banded together to create a community playgroup for their children. (Contributed by Katy Cochran, early childhood educator)

Our program jumped into the middle of a community effort to save the respite nursery, which was about to become another fatality of the state's economic downturn. Fortunately, several agencies banded together to save it. Spearheaded by Hawaii's Part H agency (Zero-to-Three Hawai'i Project), Queen Lili'uokalani Children's Center (QLCC), and our Healthy and Ready to Learn Center (HRTL), a community group met to plan next steps. After many meetings, the group made plans to start a neighborhood playgroup, led by QLCC, in a mini-park in Waipahu. Families from a couple of neighborhoods came together to talk about options for child care and preschool. As a result, the families decided to organize a playgroup with the help of QLCC staff. Because two families from HRTL were helping to organize the playgroup, we volunteered to help facilitate some playgroups with the QLCC staff during the first six months. Because of our experience coordinating the HRTL playgroups, we attended an organizing meeting with the QLCC staff and family representatives and helped design the playgroup. Besides looking at the safety and health aspects of the playgroup, we gave some activity and game ideas and at times pitched in when a QLCC staff member could not run the group.

This example shows how we became involved with other community providers and families to capitalize on the mutual commitment of families, professionals, and communities. By creating this service, we were able to shift from focusing on a problem–losing the respite nursery–to envisioning possibilities. All those involved agreed that it was much easier and more effective working together to pool our resources rather than working in isolation. The YMCA has applied for federal funds to run the playgroup, which is now a part of the E'wa community's service for children and parents.

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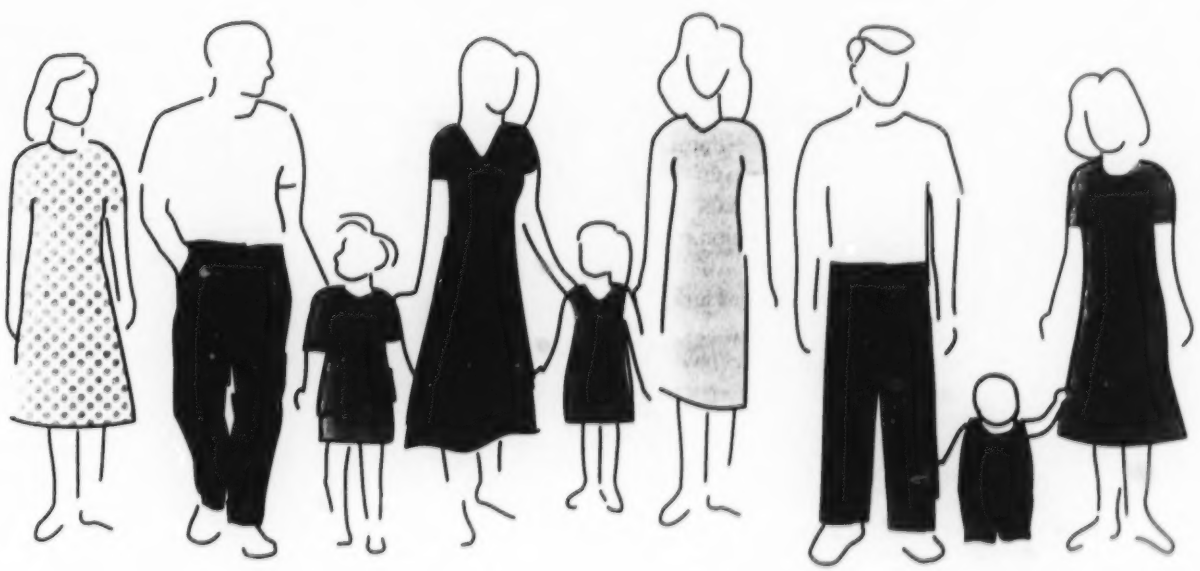
Summary

Many of America's young children and their families are in "quiet crisis." Family advocates are sounding the alarm for key leaders, practitioners, and university administrators to make fundamental changes in practice and service delivery systems. We must change the way families see themselves and interact with professionals and systems. We must change the way practitioners see families, hear families, and interact with families and other service providers. We must change the way university programs teach students about the role of families. This monograph offers a new approach to service delivery and training to families, practitioners, and communities that will lead to more positive outcomes–healthy learners, successful in life.

We credit Drs. Merle McPherson, Vince Hutchins, Dean Corrigan, Tom Behrens, Bonnie Strickland and many others for having the vision and courage to offer our collaborative grants the opportunity to participate in changing these systems. This monograph describes the family-centered interprofessional collaboration approach, chronicles the developmental stages and lessons learned in implementation, and cites practice examples. It is hoped that other communities, challenged by this approach, are motivated to make the kind of changes that develop effective relationships between families and professionals so that all children and families benefit.

The potential possibilities of any child are the most intriguing and stimulating in all creation.

–Richard Dana



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Appendix A:
Updates on MCHB Demonstraton Projects

National Commission on Leadership in Interprofessional Education (NCLIE)

The National Commission on Leadership in Interprofessional Education (NCLIE) was initiated in the Fall of 1992 and sponsored for its first three years by the Association of Teacher Educators. Its purpose is to shape a national agenda that will make coordinated, family-centered, community-based, culturally competent services a reality. It hopes to accomplish this by developing the capacity of future leaders in education, health, and human services professions to view the problems of families from a broader interprofessional perspective. Fifty-five representatives from social work, public health, law, criminal justice, psychology, extension, medicine, theology, education, etc. are members of the Commission. The basic criterion for membership is actual involvement in the development, implementation, and evaluation of integrated services and inter-professional education. Now in its second phase of development, the Commission is balancing the number of members it has from each profession so that it will be truly interprofessional.

The NCLIE comes together to share lessons learned and to connect with others who are interested in creating family-centered, culturally competent, community-based education, health, and human service systems. Each Commission meeting is organized as an "inquiry seminar." At the meetings, multidisciplinary teams present their ideas and case studies of actual programs in a panel format, and participants react to those case studies, share research and other resource materials, and respond to questions identified by the Commission to guide its work.

The Commission has begun to share its ideas and products through national and state meetings of participating professions. Commission meetings have been held in conjunction with the national conferences of the participating professions (e.g., Association of Teacher Educators, Council of Social Work Education). Dialogue has been established within each profession's networks, and concept papers and articles on integrated services and interprofessional collaboration have appeared in some professional associations' publications. An extensive library including over 50 case studies, newsletters, and other descriptive materials of new programs has also been compiled by the Commission.

The most recent meeting of the Commission was held in Albuquerque, New Mexico on May 28-29, 1996, in conjunction with the International Parent-to-Parent Conference. Since its inception the Commission has been seeking a dialogue with parents regarding their views of community-based integrated services and interprofessional education. This event provided the opportunity to strengthen that linkage with families as partners. Discussion focused on what is meant by family-centered education, health, and human service systems.

In addition, Family Voices, a national family organization which participated in this conference, is also involved in designing and implementing integrated services and interprofessional training programs. They identified clearly their expectations for collaborative "family friendly" education, health, and human service systems and, from their personal experiences, they defined essential characteristics of effective service providers. For example, a piece of advice one parent gave educators in the room was: "If they can't learn the way you teach, then you'd better learn to teach the way they learn."

The Commission plans to continue its linkage with the International Parent-to-Parent group and Family Voices. In the future, family representatives will be a part of the membership and governance of the Commission. Also, a social worker will be added as a co-chair of the NCLIE with the current co-chairs from education and health. Down the road, the Commission will disseminate lessons learned regarding the common core of "family-centered" knowledge, skills, and values that should be included in interprofessional training and research programs. The design of a variety of interprofessional education programs including what, where, and when appropriate curriculum and field experiences should be offered will be drawn from the examination of the roles and role relationships of the professional partners involved in family-centered, multiple agency collaborative systems that are getting underway throughout the country.

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The following goal statement guides the work of the Commission:

Through a family/professional partnership, the Commission will support the preparation of a new generation of interprofessionally oriented leaders in health, education, and social work who possess the knowledge, skills, and values to practice in the new community-based integrated service delivery systems.

The NCLIE will focus on interprofessional preparation in both pre-service and continued professional development. The best community-based practices with children and families will serve as knowledge bases by which changes are made in university missions and programs.

Higher Education Curricula for Integrated Services Providers

The overall goal of the Oregon project, Higher Education Curricula for Integrated Services Providers, now in its third year, is to continue to assist selected colleges and universities to develop offerings that will cross train their students in the various disciplines so that upon graduation they can affect integrated services at the local level. The first phase, identifying family-centered, community-based projects across the country that have been successful in applying an integrated service approach that benefits at-risk families, children, and youth, is complete, and a report is available. An annotated bibliography on resources for integrated services is also complete and available. Two academic sites, California State University at Fresno and the University of New Mexico, have been selected to develop curricula and create training programs for integrated services. Two or more colleges or universities will also be selected within the next few months to take part in this project. Project staff will 1) continue to work on the selection of these new sites, 2) assist them in preparing individual plans including evaluations, 3) publish an addendum to the annotated bibliography, and 4) publish the bi-annual newsletter, along with other periodical reports. For additional information, please contact: Dr. Vic Baldwin, Project Director, Teaching Research Division, Western Oregon State College, 345 N. Monmouth Avenue, Monmouth, OR, 97361, (503) 838-8401, (503) 838-8159 fax.

Partnerships for Change

The overall goal of the Partnerships for Change Project is to improve service delivery to children with special health needs and their families by working with family and professional groups to implement changes in the education and practices of professionals. Through focus groups, interviews, and surveys with families, professionals, students, and faculty, the project is compiling information which is being used to develop curricula and training materials about interprofessional collaboration and to support the inclusion of relevant content in pre-practice and in-service education for all disciplines. In order to develop models of community practice, the project is conducting qualitative research with children with special health needs, their families, and the professionals with whom they work and collecting descriptions of programs that demonstrate family-centered interprofessional collaborative practice. The outcome will be the dissemination of recommendations, strategies, and products which highlight promising practices in the community. Products that are currently available include: bibliographies: "Interprofessional Education and Practice" and "Interprofessional Education and Practice: A Selected Bibliography of Family Authored and Family/Professional Co-Authored Literature"; draft conceptual framework: "Family and Interprofessional Collaborative Education and Practice"; paper: "Interprofessional Education and Practice: A Pilot Social Work Student Survey"; a survey instrument to measure interprofessional content in the social work curriculum; and Information Exchange bulletins. Products that are in process include: publication of the proceedings of the NCLIE meeting: "The Family Connection: Family and Interprofessional Partnerships"; position paper on the conceptual framework; annotated bibliographies; compilation of selected family authored and family/professional co-authored literature; social work teaching module and curriculum changes; paper summarizing recommendations of a family/professional focus group on community practice; presentation/training materials. For more information, please contact Kathleen Kirk Bishop, Project Director, Partnerships for Change, Department of Social Work, University of Vermont, 228 Waterman, Burlington, VT, 05405-0160. Phone: (802) 656-8800. e-mail: kbishop@moose.uvm.edu.

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